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Zippping up or zippping down

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Back in the summer of 2008 one of the authors of this paper was doing research concerning integration and the reconfiguration of “social care roles” in community services caring for older people and people with severe and enduring mental health problems (Huby *et al.*, 2010). He was interviewing a manager of rural mental health service in Scotland. When asked about integration, the manager thought a bit and then said the following:

It's like a zipper that's been kind of zipped up halfway. You know you've got lots of integration going on a kind of lower levels and at the further up. The kind of higher up you go it kind of comes apart a bit. And I think that's probably quite a good way of describing. It's quite a good visual for it.

In evoking the image of a halfway-up zipper the manager could be interpreted as doing three things.

First, he was making a distinction between “lower levels” and “further up”. Within this topological configuration of the service the lower levels is where teams of co-located professionals, doctors, nurses, social workers and occupational therapists, were busying themselves with the work of actually supporting those living in the community with a mental illness. “Further up” was the place where regional strategies for realising national policy ambitions were formulated and enacted. This work of management and policy implementation was distributed across a complex network of senior and middle managers who came together and pulled apart in various configurations of working groups and committees, but was dominated by the distinction and sometime difficult relationship between the Local Authority and Local Health Board.

Second, he was suggesting that health and social care integration was happening amongst those who were actually providing services but not so much amongst those who were managing services. How and why this was is too complex a discussion for this short paper, but within this service, and other mental health services who participated in this research, there was a pervasive view that staff in co-located multidisciplinary mental health teams “naturally” tended towards integration and role-blurring, with distinctions between, say, social workers and nurses becoming fuzzy and indistinct over time (Huby *et al.*, 2010, pp. 25-28; cf. Brown *et al.*, 2000; Nancarrow, 2004). This, many suggested, had something to do with the very nature of the work itself, much of which took place in a “grey area” between health and social care, thereby making any attempt to police a distinction between these two domains impracticable. Higher-up, in their more rarefied realms of service planning, organised by policy cultures, regimes of performance management and budgets, these distinctions were still central and fundamental to the management of the service (or indeed services). So it was like a zipper that has been zipped up halfway.

Third and finally, there is in this image an intriguing inversion of the assumptions that are implicit within recent and not so recent policy initiatives (and in this editorial, as in the papers, we are addressing policy in a devolved Scotland) designed to encourage the constitution of more seamless services by, to use a somewhat hackneyed image, breaking down the “Berlin Wall”, that divides health and social care.

The history of integration policy in Scotland now goes back more for than 15 years, starting with *Designed to Care* in 1997 and moving through *Partnership for Care* in 2003, the formation of the Joint Improvement Team and Community Health Partnerships and on up to the tabling of the *Public Bodies (Joint Working) (Scotland) Bill* in 2013 (Woods, 2001; Evans and Forbes, 2009). Though it is a broad generalisation we would argue that these policy initiatives share two features: the strong suggestion that those using services would enjoy a better quality of care, and by extensions better outcomes, if that care was better coordinated and, ideally, seamless from the point-of-view of the service-user. In the words of the “policy memorandum” accompanying the *Joint Working Bill*, the “policy ambition for integrating health and social care services is to improve the quality and consistency of services for patients, carers, service users and their families” (Government of Scotland, 2013, p. 1); and the proposition that best means achieving this more seamless constitution of services and, by extension, improved outcomes for service-users, is to reconfigure the structure of service management particularly with reference to, what Stewart *et al.* (2003, pp. 346-347) have labelled, “the local planning context”. So we have had variously the constitution of “Local Health Care Cooperatives”, “Community Healthcare Partnerships”, “Community Planning Partnerships” and now, with the *Joint Working Bill*, “Integrated Joint Boards”. Of course, these entities are not a good in themselves; rather it is hoped that by devolving the planning of community services to integrated entities one may achieve better integration at the “coal face”, to employ another metaphor often used by those interviewed as part of the study of the “reconfiguration of social care roles”. Of course whether this has and will actually work, if one can actually improve the quality of services and outcomes through the more “integrated” management of local services at the planning level, is a matter of some debate. The evidence is, at best, mixed (Audit Commission, 2011; Audit Scotland, 2011, 2013; Petch *et al.*, 2013).

In a sense then, it seems the aim of integration is to improve things at the “lower levels” and finally to improve quality and outcomes for, and from the perspective of, service users. The mechanism of achieving this aim is, however, to work from the top down: from national policy, through the local planning context and finally, as these integrated plans are designed and implemented by integrated boards, to the ongoing and everyday work of care and care management. The zipper, by this reckoning, zips down rather than up. The notion that integration may be happening on the ground, as it were, even as at a local planning level policies and procedures pull apart and devolve back into more “siloes” ways of working indicates a more complex topography of relational processes than that which we described above. Specifically, it indicates that in order to understand how care is coordinated and integrated across and between the different agents enrolled into the management and delivery of health and social care in the community we must attend to the micro-processes and everyday interactions that are happening at the lower level or the “coal face”. It also indicates that we must consider how these processes interact with local planning processes and governance arrangements, without unproblematically assuming that the former may be considered to be extensions of the later or that the later serve as the impetus for change which is either accommodated or resisted by the various professionals and support workers engaged in care-work at the “coal-face” (cf. Atwal and Caldwell, 2002; Beech *et al.*, 2013).

The papers collected in this special issue provide just such accounts of integration as process as it is “really” happening and, in really happening, how it interacts with, shapes and is shaped by the needs, wishes and experience of older people living in the community with complex care needs. In so doing they make a significant contribution to a growing corpus of small-scale studies (e.g. Hardstone *et al.*, 2004; Rees *et al.*, 2004; Welner *et al.*, 2003) which illuminate how people work together in enabling and supporting people to live full and

independent lives in the community. By focusing on micro-processes of integration, and in particular, moves towards more person-centred and outcomes-focused approaches, these studies also raise the problem of, what Gamiz and Tsegai (2014) describe as the “gap between what integration means on paper and what it means in practice” and suggest that we need to attend to the complex, and often fuzzy interplay between “formal and informal levels” of working between statutory organisations enrolled into the care of older people.

Besides the broad focus on the micro-processes of relational engagement by which care is coordinated (and sometimes uncoordinated), the papers collected share two closely allied concerns.

The first is a concern with an outcomes-oriented approach and how a personal outcomes-oriented approach may support and underpin moves to the better integration of services. This is particularly powerfully suggested by the Tsegai and Gamiz's (2014) paper in which they argue the benefits of a personal outcomes focused approach to assessment, which actively enrolls carers as equal partners in a collaborative process by which services are coordinated to achieve outcomes identified by the carers themselves. What is intriguing is the finding that the key to this more participatory outcomes approach is “conversation”, rather than “paper-based tools”, which were found to inhibit effective working with carers. These more “informal” processes of face-to-face dialogue have the effect, the authors argue, of integrating carers into the process by which care is coordinated. By extension, the carers themselves are empowered to integrate care. The creation of a more seamless service therefore depends, in part, on there being mechanisms in place that allow for service-users and carers to play a central role in the constitution and coordination of care which is directed towards desired outcomes. In other words, as Caine (2014) argues, “[w]orking in partnership with service users is at the heart of integration”. It is at the heart because this partnership becomes the locus of the coordination and integration of services and so the shift towards an outcomes-oriented approach becomes that which drives the constitution of more seamless services. Integration should work, to quote Caine, from the “bottom-up” as a process “which begins with service users and carers” and so “creates a foundation for an outcomes-focused integration of services and systems”. However, as Tsegai and Gamiz discuss, the empowerment of service and carers to become the locus of the coordination of services, is in part contingent on the better integration of services. In particular, they note the importance of having one point of contact, a “lead professional”, with whom they can collaborate so as to better carer to achieve personal outcomes” and to help in “navigating” complex service environments.

The second is a concern with participatory methods as a means of not only engaging service users and carers in the management of care, but, more fundamentally, of facilitating the better integration of services. Interestingly, this argument extends to the work of research itself. On the one hand, the authors of these papers suggest that practitioner research is useful in that allows for a better understanding of the micro-process of collaboration and integration, and in particular the integration of service-users and carers into the constitution of outcomes and the coordination of care. Colliston, for example, reflects on the fact that “peer support”, such as going to “Fairmuir clubbie has a couple of wee malt whiskies and a chat with the boys”, was particularly important to four of the five service-users she interviewed. As a practitioner-researcher, this finding has been integrated into her own work and the appreciation of “the significance of peer support from the perspective of individuals has led” her “team to look creatively at how we can maintain this support for people as they progress from the early stage support service”. On the other hand, there is the assertion that the very doing of

practitioner-led participatory research can be one of the mirco-process which allow us work from “the ground up” to better integrate services. For Caine, this is because this research process is in itself a method “for engaging people with dementia and their carers in service design and delivery”. For Gamiz and Tesige, the experience of undertaking a joint practitioner-research leads them to conclude that such projects have the potential to better integrate front-line professionals into the process of service redesign and foster “positive and open working relationships between individuals both within and between organisations”.

Given the wide brief of these practitioner led projects into support for older people, it is striking that all of them addressed the issue of health and social care integration. The extent to which the findings from the projects reinforce each other (and wider research in this area see Cameron *et al.*, 2013 for a review) is also striking, with dialogue, participation, a focus on the person using services and outcomes being identified as critical to the successful “zipping up” of health and social care. As policy pressure across the UK to “zip down” the divisions between health and social care continues to escalate, so the findings of small scale projects such as these become more important if the zippers have any chance of meeting in the middle.

John Harries and Ailsa Cook

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